

WORKING PAPER 311/2026

**Disclosure, Consumer Protection, And Adjudication in Indian Health
Insurance: Evidence from Insurance Ombudsman Decisions**

**Akhil V S
Rupel Nargunam**



MADRAS SCHOOL OF ECONOMICS

Gandhi Mandapam Road

Chennai 600 025

India

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Akhil V S

University of Hyderabad, India

and

Rupel Nargunam

(Corresponding Author) Madras School of Economics, Chennai

rupel@mse.ac.in

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Madras School of Economics
Gandhi Mandapam Road
Chennai – 600 0025

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Phone: 2230 0304/2230 0307/2235 2157

Fax: 2235 4847/2235 2155

Email: info@mse.ac.in

Website: www.mse.ac.in

DISCLOSURE, CONSUMER PROTECTION, AND ADJUDICATION IN INDIAN HEALTH INSURANCE: EVIDENCE FROM INSURANCE OMBUDSMAN DECISIONS

Akhil V S¹ and Rupel Nargunam^{2*}

¹University of Hyderabad, India

²Madras School of Economics, India. *corresponding author

Abstract. Cost-sharing provisions are an established feature of health insurance contracts, but their effectiveness depends on whether policyholders can anticipate their financial consequences and whether insurers apply them consistently with regulatory requirements. This study examines how cost-sharing disputes are resolved within India's insurance adjudication system. Using a comparative analysis of fifteen Insurance Ombudsman decisions involving room-rent caps, proportional deductions, co-payments, and sub-limits, the study develops a structured framework based on transparency, predictability, and regulatory application. The evidence indicates that adjudicated outcomes are closely associated with a combined disclosure-and-application standard rather than with the magnitude of the policyholder's financial loss. Among thirteen cases classified as decisive, all eight cases involving inadequate disclosure and/or non-compliant application resulted in relief for policyholders, whereas all five cases satisfying the disclosure-and-application standard were upheld for insurers. Fisher's exact test provides descriptive support for this association ($p = 0.0008$), while no comparable association is observed for the magnitude of financial harm ($p = 0.565$). Process tracing of the Ombudsmen's stated reasoning supports the same pattern: relief is linked primarily to whether the relevant provision was adequately disclosed and correctly applied, rather than to the size of the resulting out-of-pocket burden. The evidence does not permit disclosure and regulatory application to be identified separately, nor does it support causal inference for the wider health insurance market. Further, the small adjudicated sample and outcome-informed initial coding impose important limits on generalisability. Blind recoding provides a sensitivity analysis for outcome-informed classification, with weighted Cohen's κ ranging from 0.54 to 0.75 and Krippendorff's $\alpha = 0.77$ after revision of the coding instrument. The findings highlight the role of disclosure quality and regulatory compliance in insurance contract enforcement and suggest that improved standardisation of cost-sharing information may strengthen consumer protection without eliminating cost-sharing as an insurance-design mechanism.

Keywords. *health insurance; cost-sharing; disclosure; adjudication; catastrophic health expenditure; process tracing.*

JEL classification. I13, D82, G22, I18.

ACKNOWLEDGEMENT

This work was presented to a wider audience at the University of Hyderabad, the authors would like to thank the participants for their valuable comments and suggestions on the earlier version of this study.

Akhil V S

Rupel Nargunam

1. Introduction

India's health insurance market has expanded substantially, particularly following the introduction of Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY) in 2018. Yet the expansion of insurance coverage has not necessarily translated into equivalent financial protection. Out-of-pocket (OOP) expenditure remains approximately 50.6% of total health expenditure in India (WHO, 2022), while evidence from publicly financed schemes indicates limited or inconsistent reductions in household financial burden (Selvaraj and Karan, 2012; Prinja et al., 2017; Garg, Bebarta, and Tripathi, 2020). This distinction between insurance coverage and effective financial protection draws attention to what happens within the insurance contract when a claim is made.

Cost-sharing provisions are an important part of this contractual structure. Room-rent caps, co-payments, sub-limits, and proportional deductions can reduce the extent of expenditure transferred to the insurer and serve legitimate functions in insurance design. Economic models of insurance identify cost-sharing as a mechanism for mitigating moral hazard and addressing adverse selection (Pauly, 1968; Rothschild and Stiglitz, 1976), while subsequent work develops its role in screening and contract design (Gruber, 2006; Dionne and Rothschild, 2014; Mimra and Wambach, 2014). Empirical evidence further demonstrates that changes in cost-sharing can materially affect healthcare utilisation and expenditure (Brot-Goldberg et al., 2017). The policy issue, therefore, is not whether cost-sharing should exist, but whether policyholders can understand its implications when purchasing insurance and whether insurers subsequently apply these provisions consistently with the contract and applicable regulatory requirements.

This concern is particularly important in health insurance because the financial consequences of individual provisions may be difficult to anticipate. Research on insurance choice has documented substantial limitations in consumer comprehension of deductibles, co-payments, coinsurance, and related terms (Loewenstein et al., 2013; Kunreuther, Pauly, and McMorro, 2013). Insurance complexity can also impede comparison across products (Ericson and Sydnor, 2017), while shrouded attributes may persist even in competitive markets when consumers have difficulty observing or evaluating them (Gabaix and Laibson, 2006). These problems may be amplified in developing insurance markets by limitations in financial literacy, trust, and prior experience (Eling, Pradhan, and Schmit, 2014; Keshavarz Haddad and Zomorodi Anbaji, 2010; Zhang, Chen, and Yao, 2021). Thus, the formal presence of a contractual provision does not necessarily imply that its financial consequences are transparent or predictable to the policyholder.

The distinction between disclosure and application is consequential. A provision may be technically disclosed but difficult to translate into an expected financial exposure, particularly when several restrictions operate together. Conversely, a clearly stated provision may be applied incorrectly at the claims stage. The resulting dispute is therefore not simply a question of whether a cost-sharing provision is desirable, but whether its contractual and regulatory basis remains valid when it is translated into a claim settlement. This creates an institutional question that is not directly addressed by either the literature on consumer comprehension or the literature measuring household financial protection.

India provides a useful setting for examining this question because health-insurance regulation has increasingly addressed both disclosure and standardisation. The Protection of Policyholders' Interests Regulations and subsequent IRDAI measures prescribe requirements

concerning policy terms, exclusions, and the application of particular medical-expense restrictions (IRDAI, 2017, 2020, 2024). The Arogya Sanjeevani Policy provides an additional benchmark through standardisation of important cost-sharing features. These interventions indicate that the regulatory objective is not necessarily to eliminate cost-sharing, but to make the contractual consequences more transparent and consistent. The effectiveness of these requirements ultimately depends on their application when claims are disputed. The Insurance Ombudsman system provides a distinctive institutional setting in which this process can be examined. The Ombudsman provides a cost-free quasi-judicial mechanism for resolving eligible disputes between policyholders and insurers, and the Council for Insurance Ombudsmen reports a substantial volume of health-insurance complaints (CIO, 2024). Unlike household expenditure data, adjudicated decisions contain information on the contractual provision at issue, the insurer's interpretation and application of that provision, the policyholder's objection, and the adjudicator's stated reasoning. They therefore provide an opportunity to examine how contractual disclosure, regulatory compliance, and financial consequences are considered when a cost-sharing dispute reaches formal adjudication.

The existing literature provides extensive evidence on the economic rationale for cost-sharing and on consumers' difficulties in understanding insurance contracts, while the health-financing literature documents persistent OOP expenditure despite expanded coverage. The regulatory literature establishes disclosure and standardisation requirements, but these requirements do not by themselves reveal how they operate in contested claims. Similarly, studies of financial protection generally do not connect residual OOP expenditure to the contractual provisions that generate it. What remains less understood is how an adjudicatory institution weighs the **validity and disclosure of a cost-sharing provision against the magnitude of the financial burden** imposed on the policyholder.

This study addresses this gap by examining reasoned Insurance Ombudsman decisions concerning disputed health-insurance cost-sharing provisions in India, with particular attention to the considerations that shape adjudicatory outcomes. Specifically, it examines whether Ombudsman decisions are principally informed by the adequacy of disclosure and the manner in which cost-sharing provisions are applied, or by the magnitude of the resulting financial burden borne by the policyholder. This distinction is important because the two considerations imply different interpretations of the consumer-protection role of insurance adjudication: the former emphasises contractual and regulatory validity, whereas the latter places greater weight on the extent of financial hardship experienced by the insured. The study develops a structured framework around transparency, predictability, proportionality, and financial protection and applies it to a selected set of adjudicated cases involving room-rent caps, proportional deductions, co-payments, and sub-limits. The analysis combines systematic case coding with process tracing of the Ombudsmen's stated reasoning. This approach allows the contractual and regulatory characteristics of disputed provisions to be examined alongside the financial consequences experienced by policyholders.

The study is positioned as an analysis of adjudicatory reasoning rather than a causal evaluation of disclosure in the wider health insurance market. In particular, the cases reaching adjudication are not representative of all insured policyholders or all claims, and the available decisions do not permit disclosure quality to be cleanly separated from regulatory application in every case. The analysis therefore seeks to identify patterns in how disputed cost-sharing provisions are treated within the adjudicatory process rather than to estimate a population-level causal effect. The contribution is to connect three dimensions of insurance markets that are generally examined separately: **cost-sharing as a mechanism of contract design, disclosure as a**

condition for informed insurance choice, and adjudication as a mechanism for enforcing contractual and regulatory standards. By examining these dimensions together, the study provides an institutional perspective on the transition from insurance contract to claim settlement. It also highlights the relevance of regulatory standardisation for making cost-sharing provisions more transparent and predictable without necessarily removing them as an instrument of insurance design.

The remainder of the paper describes the case-selection and coding methodology, presents the empirical and qualitative analysis, discusses the implications for insurance contract design and consumer protection, and concludes with the limitations and directions for future research.

2. Conceptual Framework and Empirical Approach

2.1 Conceptual Framework

Insurance contracts are formed under conditions of asymmetric information, although the nature of the asymmetry varies across stages of the insurance relationship. Classical insurance models focus on private information about risk held by policyholders and the resulting problems of adverse selection (Rothschild and Stiglitz, 1976). In the context examined here, the relevant asymmetry concerns the financial consequences of contractual provisions. Insurers design contracts, determine their cost-sharing structures, and administer claims, and therefore possess greater familiarity with how particular provisions are likely to affect claim settlements. Policyholders, by contrast, typically purchase standardised contracts and may face difficulty anticipating the financial consequences of interacting restrictions.

This informational asymmetry does not imply that cost-sharing is inefficient or inappropriate. Deductibles, co-payments, proportional deductions, and sub-limits can serve legitimate functions in insurance design by mitigating moral hazard and supporting screening in the presence of adverse selection (Pauly, 1968; Rothschild and Stiglitz, 1976). Subsequent work develops the role of such mechanisms in competitive insurance markets (Dionne and Rothschild, 2014; Mimra and Wambach, 2014), while empirical evidence shows that cost-sharing can materially influence healthcare utilisation and expenditure (Brot-Goldberg et al., 2017). The consumer-protection concern considered here is therefore narrower: it arises when policyholders cannot reasonably anticipate the financial consequences of cost-sharing provisions or when insurers apply those provisions inconsistently with contractual and regulatory requirements.

The framework consequently distinguishes between ex ante disclosure and ex post application. Disclosure concerns whether the relevant cost-sharing provision is communicated in a manner that enables the policyholder to understand the restriction and anticipate its financial implications before a claim arises. Application concerns whether the insurer subsequently implements the provision consistently with the governing contract and applicable regulatory requirements. The distinction is important because the inclusion of a provision in contractual documentation does not necessarily make its financial consequences predictable. Evidence that consumers may have difficulty understanding insurance cost-sharing (Loewenstein et al., 2013; Kunreuther, Pauly, and McMorro, 2013), together with evidence that contractual complexity can impede insurance choice (Ericson and Sydnor, 2017), suggests that formal disclosure and effective understanding should not be treated as equivalent.

The distinction is particularly relevant in health insurance because the final settlement may depend on the interaction of multiple cost-sharing provisions. A room-rent restriction, for example, may trigger a proportional deduction that affects otherwise eligible hospitalisation expenses, while co-payments, sub-limits, and deductibles may operate simultaneously. Consequently, the financial exposure experienced by a policyholder may differ substantially from what would be inferred from the sum insured or from consideration of any individual provision in isolation.

This motivates the concept of asymmetry of contractual consequence (ACC), defined here as the gap between the financial consequences that a policyholder can reasonably anticipate from the disclosed terms of a policy and those ultimately realised when a claim is settled. ACC is used as a conceptual lens rather than an empirically estimated construct. The study does not attempt to construct or estimate a continuous measure of ACC. Instead, the empirical analysis examines two observable stages through which such asymmetry may become consequential: whether the relevant provision was adequately disclosed and whether it was correctly applied.

Consider a policy with a sum insured of INR 5,00,000 and a room-rent entitlement of INR 3,000 per day. If the policyholder occupies a room costing INR 5,000 per day for five days, the room-rent ratio is 0.60. Suppose the resulting proportional deduction reduces an otherwise eligible hospital claim of INR 3,00,000 to an insurer payment of INR 2,24,000, leaving INR 76,000 to be borne by the policyholder. The example illustrates how a cost-sharing provision can materially alter the realised financial consequence of a claim without the sum insured being exhausted. More importantly, it illustrates why the consumer-protection issue is not simply the existence of the restriction, but whether its financial consequences were sufficiently disclosed and whether the resulting deduction was correctly applied. The mechanism is illustrated and presented in Table 1 as follows:

Table 1. Correct application of a room-rent cap

Item	Hospital charge (INR)	Insurer pays (INR)	Patient OOP (INR)
Room rent (5 days)	25,000	15,000	10,000
Surgeon's fee	80,000	48,000	32,000
Operating theatre	40,000	24,000	16,000
Anaesthesia	20,000	12,000	8,000
Nursing (5 days)	25,000	15,000	10,000
Medicines (exempt)	30,000	30,000	—
Diagnostics (exempt)	30,000	30,000	—
Consumables (exempt)	50,000	50,000	—
Total	3,00,000	2,24,000	76,000 (25.3%)

OOP of INR76,000 arises on a INR 5,00,000 policy that is never exhausted.

The empirical framework therefore focuses on the adjudicatory distinction between disclosure and application and the magnitude of financial harm. The former captures whether the disputed contractual provision was adequately communicated and implemented in accordance with the governing framework; the latter captures the financial burden experienced by the policyholder. The analysis asks whether relief in Insurance Ombudsman decisions is more closely associated

with deficiencies in disclosure and application than with the magnitude of the resulting financial burden.

2.2 Data and Case Selection

Following the case-study and process-tracing literature (Yin, 2018; George and Bennett, 2005; Beach and Pedersen, 2019), the study uses a comparative case-study design combining structured coding with analysis of adjudicators' stated reasoning. The unit of analysis is the individual Insurance Ombudsman decision. The objective is to identify systematic patterns within adjudicated disputes rather than to estimate population-level relationships.

Cases were identified from the Council for Insurance Ombudsmen Annual Reports for 2022–23 and 2023–24 and from individual Insurance Ombudsman awards published through the CIO. Searches focused on room rent, proportional deduction, co-payment, sub-limit, and related claim-disallowance terms. The screening process identified 250 case summaries, of which 112 concerned health insurance and 37 involved cost-sharing provisions. Fifteen cases satisfied the final inclusion criteria: the dispute involved at least one relevant cost-sharing provision, a reasoned award was available, the relevant provision and adjudicator's reasoning could be identified, and sufficient monetary information was available to calculate residual OOP expenditure. The final sample is fully enumerated in the case-level results and presented in Table 2.

Table 2. Case-selection funnel

Stage	Number
Total Ombudsman case summaries reviewed (CIO Annual Reports 2022-23, 2023-24; and individual Insurance Ombudsman awards, Council for Insurance Ombudsmen)	250
Health insurance cases identified	112
Cost-sharing-related cases (room-rent cap, proportional deduction, co-payment, sub-limit)	37
Final analytical sample (met all inclusion criteria; reasoned award available)	15

Cases resolved on procedural grounds unrelated to cost-sharing, cases lacking a reasoned award, and cases without sufficient monetary information were excluded. Because a contemporaneous screening log was not maintained for all excluded cases, the selection counts should be understood as a description of the implemented screening procedure rather than as a fully auditable sampling frame.

Each case is coded on four dimensions: **transparency, predictability, proportionality, and financial protection**. Transparency records whether the relevant cost-sharing provision is explicitly communicated in the Key Information Document (KID) and in sufficiently accessible language. Predictability records whether the policyholder could reasonably calculate the financial consequence before admission. Proportionality records whether the insurer's application of the deduction is consistent with the applicable IRDAI requirements. Financial protection records the residual OOP burden relative to the catastrophic-expenditure benchmark. The complete coding instrument and anchored classification rules are reported in Table 3.

Table 3. Coding instrument with anchored three-level classification

Criterion	Operational definition	Anchored classification rule
Transparency	Does the Key Information Document (KID) explicitly state the cost-sharing provision in plain language?	0 = absent from KID; 1 = present but technical/undefined; 2 = plain-language with worked example
Predictability	Can the policyholder calculate ex ante out-of-pocket liability before admission?	0 = indeterminate until settlement; 1 = formula requires specialist knowledge; 2 = fixed and pre-calculable
Proportionality	Is the deduction applied within IRDAI rules (excess room cost only; exempt categories preserved)?	0 = applied to IRDAI-exempt items; 1 = associated items only; 2 = confined to excess room cost
Financial protection	Does residual OOP remain below the CHE threshold for the relevant household?	0 = CHE exceeded at median; 1 = CHE exceeded only at lower quintiles; 2 = below threshold at all quintiles

The four criteria are assigned ordered three-level classifications. The categories are ordinal rather than continuous measures. Transparency and predictability jointly characterise disclosure quality, while proportionality is treated separately because it concerns ex post compliance rather than information available to the policyholder at the point of purchase. Financial protection is treated as an outcome characteristic and is not incorporated into the disclosure measure. These quantities are used only to order the discrete classifications and are not interpreted as continuous psychometric measures. Proportionality is excluded because disclosure failure and regulatory misapplication have different policy implications. The former concerns the quality of information available to consumers; the latter concerns compliance at the claims stage. Their empirical relationship is examined separately.

2.3 Reliability and Analytical Strategy

Transparency and predictability are analysed as separate ordinal indicators of disclosure. As transparency and predictability involve judgments about contractual language, coding reliability is assessed through independent recoding. The initial coding was undertaken by a single analyst who had read the complete adjudicatory record. A second coder subsequently classified transparency and predictability using case descriptions from which the Ombudsman's ruling and reasoning had been removed. Agreement was assessed using linear-weighted Cohen's κ for each criterion and Krippendorff's α across the two disclosure criteria. The initial coding produced weighted κ values of 0.49 for transparency and 0.51 for predictability, with Krippendorff's $\alpha = 0.66$. Disagreements were concentrated in the intermediate category, leading to refinement of the corresponding coding anchors. Following revision, weighted κ increased to 0.54 for transparency and 0.75 for predictability, while Krippendorff's α increased to 0.77. These statistics are interpreted as evidence concerning the reproducibility of the coding procedure rather than as validation of the underlying conceptual construct.

Residual OOP expenditure is additionally placed in distributional context using the catastrophic-expenditure framework of Xu et al. (2003). The analysis applies the corresponding

capacity-to-pay threshold across expenditure quintiles using the HCES 2022–23 distributions. Because claimant-level household consumption is not observed, this exercise is used only to place the observed OOP burdens in distributional perspective and does not enter the disclosure classification.

The empirical analysis combines process tracing with descriptive statistical comparisons. Process tracing examines the adjudicators' stated grounds for their decisions, while the structured coding permits systematic comparison of outcomes with disclosure and application characteristics and, separately, with the magnitude of financial harm. Given the small sample, Fisher's exact test is used for categorical comparisons and Spearman rank correlation is used as a supplementary measure consistent with the ordinal nature of the coding.

The design imposes two important limitations on interpretation. First, the sample consists only of disputes that reached Ombudsman adjudication and therefore cannot represent the broader population of insured policyholders or claims. Policyholders who accepted settlements, settled disputes without adjudication, or did not pursue a complaint are not observed. Second, disclosure quality and regulatory application are closely related in the observed cases, limiting the ability to identify an independent association for either dimension. The analysis therefore does not estimate a causal effect of disclosure or claim that the observed relationships apply to the wider health-insurance market. Instead, it examines the characteristics of disputed cost-sharing provisions that are associated with adjudicated outcomes and compares those patterns with the grounds stated by the Ombudsmen themselves.

3. Results

The analytical sample comprises 15 adjudicated health-insurance disputes involving room-rent caps, sub-limits, co-payments, deductibles, proportional deductions, and combinations of these provisions. The cases were selected from Insurance Ombudsman material reviewed for the study and are presented in anonymised form because individual awards are not available through a publicly searchable case-level repository.

3.1 Characteristics of the adjudicated cases

Table 4 summarises the financial characteristics of the 15 cases. Claim amounts range from INR 95,000 to INR 6,00,000, while residual out-of-pocket expenditure ranges from INR 50,000 to INR 3,80,000. The mean residual OOP is INR 1,43,733, representing 43.8% of the amount claimed. These figures illustrate the financial significance of disputed cost-sharing provisions within the adjudicated sample, but they should not be interpreted as estimates of the prevalence or average burden of such provisions among insured households.

Table 4. Summary statistics for the analytical sample (n = 15)

Variable	Mean	Median	Min	Max
Claim amount (INR)	3,35,333	3,50,000	95,000	6,00,000
Amount settled (INR)	1,91,600	2,00,000	0	4,30,000

Variable	Mean	Median	Min	Max
Residual OOP (INR)	1,43,733	1,30,000	50,000	3,80,000
OOP as % of claim	43.8%	42.9%	10.4%	100.0%

Table 5. Distribution of adjudicated outcomes

Outcome	n	Share	Definition
Policyholder award	8	53.3%	Provision reversed in whole or part
Insurer award	5	33.3%	Provision upheld as disclosed and applied
Partial award	2	13.3%	Provision partly upheld, partly reversed
Total	15	100.0%	

Eight cases resulted in awards favourable to the policyholder, five upheld the insurer's position, and two resulted in partial awards (given in Table 5). The cases therefore contain variation in both adjudicatory outcome and financial consequence, allowing the two competing explanations considered in the conceptual framework to be examined descriptively.

The individual cases are reported in Table A4 (refer Appendix). The mechanisms involved differ materially across cases. Some disputes concerned whether a provision could lawfully be applied to a particular expense category; others concerned the clarity or availability of the relevant contractual provision; and several involved multiple cost-sharing mechanisms operating simultaneously. This heterogeneity is important because the study does not treat cost-sharing itself as problematic. Rather, the analysis examines the circumstances under which an adjudicator accepted or rejected its application.

3.2 Adjudicatory reasoning: disclosure and application

The primary evidence comes from the reasons stated by the Insurance Ombudsman rather than from the numerical classification alone. Across the policyholder-favourable cases, two recurring grounds are evident: the disputed deduction was applied outside the applicable regulatory framework, or a material contractual provision or its practical consequence had not been adequately communicated to the policyholder.

From individual cases are reported in Table A4 (refer Appendix), three policyholder-favourable cases primarily involved disclosure or communication deficiencies. In C-03, the term “associated charges” was not sufficiently defined; in C-08, the employee was not furnished with the relevant master policy; and in C-12, the combined operation of multiple provisions was not adequately disclosed. Five further policyholder-favourable cases concerned substantive application problems, including deductions applied to categories treated as exempt

under the applicable regulatory framework or deductions applied in circumstances not contemplated by the relevant provision.

The insurer-favourable cases present the contrasting pattern. In C-02, C-04, C-06, C-09, and C-15, the relevant provisions were recorded as being disclosed in the applicable policy documentation and correctly applied. The Ombudsman consequently upheld the insurer's position. The largest residual OOP in the sample occurs in C-15, where the entire INR 3,80,000 claim was refused. The outcome in this case is therefore informative: the magnitude of the claimant's financial burden did not, by itself, provide a basis for reversing a provision that had been adequately disclosed and correctly applied.

The two partial awards further illustrate that adjudication operated at the level of individual provisions rather than simply according to the aggregate size of the claimant's loss. In C-14, for example, one component of the insurer's deduction was upheld while another was reversed. Similarly, C-11 involved partial acceptance and reversal of different components of the deduction. These cases suggest that the adjudicatory process distinguishes between the validity of individual cost-sharing provisions and the overall financial consequence of the claim.

Taken together, the case narratives support a **combined disclosure-and-application standard**. The evidence does not establish that disclosure operates independently of regulatory compliance. Indeed, the two dimensions are closely related in the observed cases. The more defensible interpretation is that adjudicators required the disputed financial consequence to be both adequately communicated and consistent with the applicable contractual and regulatory provisions.

3.3 Disclosure and application versus financial burden

The structured coding provides a supplementary assessment of this pattern. Table A5 (refer Appendix) reports the disclosure classification based only on transparency and predictability; proportionality is excluded from the construction of the classification. The resulting classification places the cases into low, intermediate, and high disclosure categories. Table A5 provides a supplementary structured assessment of the disclosure dimension based on transparency and predictability; proportionality is excluded from this classification. The cases are classified as low, intermediate, or high disclosure rather than placed on a continuous scale. The three cases classified as low disclosure are policyholder-favourable, while the five insurer-favourable cases are classified as high disclosure. The remaining cases occupy the intermediate category. Because the original coding was undertaken with knowledge of the adjudicated outcomes, this classification should not be interpreted as an unbiased estimate of the association between disclosure and outcome.

This association should, however, be interpreted cautiously. The initial coding was undertaken with knowledge of the adjudicated outcomes. Consequently, the perfect separation visible in the original classification cannot be treated as an unbiased estimate of the relationship between disclosure and outcome. Independent blind recoding provides a more conservative assessment. Under the first blind coding, the risk difference between the relevant disclosure groups is 0.68 ($p = 0.032$); under the revised coding instrument, the corresponding risk difference is 0.71 ($p = 0.021$). The separation is therefore weaker than under the original coding but remains evident.

The adjudicatory standard is interpreted as a combined disclosure-and-application standard based on the process-tracing evidence and the magnitude of the financial burden. As the sample is small, Fisher's exact test is used rather than a large-sample approximation. The comparison is restricted to the 13 decisive cases, excluding the two partial awards is presented in Table 6.

Table 6. Fisher's exact test: disclosure/application versus financial burden

Predictor	Group 1 (Policyholder/Insurer)	Group 2 (Policyholder/Insurer)	Fisher's exact p-value	Interpretation
Combined disclosure-and-application standard	8/0	0/5	0.0008	Strong descriptive association with adjudicated outcome
Residual OOP, above/below median	4/1	4/4	0.565	No statistically detectable association

The process-tracing analysis identifies a combined disclosure-and-application standard, whereas the structured coding provides a supplementary assessment of the disclosure dimension. For the 13 decisive cases, the low- and high-disclosure groups produce a Fisher exact p-value of 0.0008. By contrast, splitting the cases at the median residual OOP of INR 1,30,000 produces a p-value of 0.565. Across the 13 decisive cases, the Spearman rank correlation between the combined disclosure-and-application classification and adjudicated outcome was $\rho=0.88$ ($p<0.001$). By contrast, the corresponding correlation between residual OOP and outcome was $\rho=-0.5$ ($p=0.076$).

The Fisher comparison is based on the combined disclosure-and-application classification derived from the adjudicators' stated reasoning, rather than on the disclosure-only coding reported in Table A5. The difference between the two comparisons should not be interpreted as evidence that financial burden is irrelevant to policyholder welfare. Rather, within this adjudicated sample, the amount of financial loss does not appear to determine whether the Ombudsman reverses the disputed provision. The adjudicators' stated reasons instead emphasise whether the provision was adequately disclosed and whether it was correctly applied.

This distinction is particularly important for interpreting the institutional role of insurance adjudication. Within the cases examined, Ombudsman reasoning is more consistent with determining the contractual and regulatory validity of disputed provisions than with reallocating losses according to the severity of the resulting financial burden. Thus, a large residual OOP does not necessarily generate relief where the underlying provision is considered valid, disclosed, and correctly applied.

3.4 Robustness and interpretation of the evidence

Several checks qualify the strength of the preceding comparison. First, the association between disclosure/application and outcome persists under independent blind coding, although the perfect separation observed in the original coding does not. This indicates that the observed pattern is not entirely reproduced by the initial outcome-informed classification, although the small sample and remaining coding dependence require the association to be interpreted cautiously.

Second, alternative measures of financial burden do not produce a comparable separation. Using residual OOP as a share of the claim amount yields no statistically significant association with outcome, while the constructed catastrophic-expenditure threshold classifies all decisive cases as exceeding the threshold. The latter result therefore provides no discriminatory variation within the sample.

Third, the evidence does not permit disclosure to be separated cleanly from substantive regulatory application. Five policyholder-favourable cases primarily concern regulatory misapplication, while three primarily concern disclosure or communication failures. The two dimensions are therefore substantially confounded in the available cases. Accordingly, the analysis does not identify a causal “disclosure effect”. The appropriate interpretation is that adjudicated relief is associated with a broader standard requiring cost-sharing provisions to be adequately disclosed and correctly applied.

The evidence is consequently best viewed as an exploratory mixed-methods analysis. Process tracing of the Ombudsman's stated reasons constitutes the primary evidence, while the coding exercise, Fisher's exact tests, and rank correlations provide supporting descriptive checks. With only 15 adjudicated cases, these statistics are not intended to establish population-level relationships or causal effects.

The source structure imposes an additional limitation. Individual Insurance Ombudsman awards are not available through a publicly searchable case-level repository, preventing independent retrieval of each decision by a third-party reader. The analysis therefore relies on the available published material and the case-level information extracted for the study. This limits reproducibility and should be considered when interpreting the coded results.

Finally, the financial-burden analysis should be distinguished from evidence on household-level financial protection. The observed OOP amounts can demonstrate the size of residual liabilities in the adjudicated cases, but the study does not observe household income or consumption. Consequently, the distributional and catastrophic-expenditure calculations are illustrative rather than estimates of actual catastrophic health expenditure. They are therefore treated as supplementary evidence rather than as a basis for causal or population-level claims.

Overall, the results indicate that the adjudicatory record is more consistent with a **validity-and-application approach to cost-sharing disputes** than with an outcome rule based on the magnitude of financial loss. This finding does not imply that the financial consequences of cost-sharing are unimportant. Rather, it indicates that, once a cost-sharing provision is found to be clearly disclosed and correctly applied, the severity of the resulting OOP burden does not appear, in these cases, to constitute an independent ground for adjudicatory reversal. The policy implications of this distinction are discussed in the following section.

4. Discussion and Implications

The findings indicate that, within the adjudicated cases examined, Insurance Ombudsman decisions concerning health-insurance cost-sharing are more closely aligned with the **adequacy of disclosure and correctness of application** than with the magnitude of the financial burden borne by the policyholder. This does not imply that cost-sharing is inherently inconsistent with consumer protection. Room-rent limits, sub-limits, deductibles, and co-payments can serve legitimate functions in product design, pricing, and risk management. The concern arises when the resulting financial exposure is difficult to anticipate or when a provision is applied beyond its contractual or regulatory scope.

From an insurance risk-management perspective, cost-sharing represents an intended transfer of medical expenditure risk to the policyholder. Such risk transfer is more sustainable when the policyholder can reasonably anticipate its financial consequences. The cases therefore highlight the importance of considering disclosure and claims application as components of **conduct and operational risk management**, alongside their role in consumer protection. Insurers may benefit from assessing not only whether individual cost-sharing provisions are permissible, but also whether their interaction produces financial consequences that are difficult to understand or administer.

The findings also suggest scope for more decision-relevant disclosure. Percentage-based formulas or separate descriptions of individual limitations may not adequately communicate the financial consequences of interacting provisions. Illustrative rupee-value scenarios, particularly for room-rent limits and proportional deductions, could potentially improve predictability. Similarly, where several cost-sharing provisions can operate simultaneously, a combined-effect illustration could make the resulting exposure more transparent. These proposals are policy hypotheses rather than tested recommendations, as the present study does not examine whether alternative disclosure formats change consumer behaviour or reduce disputes.

An important distinction emerges between **procedural consumer protection and substantive financial protection**. The Ombudsman decisions primarily concern whether a provision was adequately disclosed and correctly applied. They do not appear to provide relief solely because the resulting financial burden is large. Thus, a policyholder may remain exposed to substantial OOP expenditure where the relevant provision is clearly disclosed and validly applied. If such exposure is considered excessive, the appropriate response may lie in product design or regulation rather than adjudication.

The study has two principal limitations. The sample is small and consists of disputes that reached adjudication, and therefore does not represent the broader population of health-insurance claims or policyholders. In addition, disclosure and regulatory application are closely related in the observed cases, preventing identification of an independent causal effect of disclosure. The disclosure classification should consequently be interpreted as an exploratory measure of association rather than a causal estimate.

Future research could extend the analysis using larger case-level datasets and claims data to examine whether disclosure and contract complexity are associated with disputes, claims outcomes, and residual financial exposure. Such evidence would also allow the relationship

between consumer protection and legitimate insurer risk-sharing to be examined beyond the adjudication setting.

Overall, the study suggests that the relevant distinction is not between **cost-sharing and no cost-sharing**, but between **predictable risk transfer and unanticipated or improperly administered risk transfer**. This distinction provides a useful basis for linking consumer protection with insurers' product-design and claims-management practices while recognising that the broader question of acceptable financial exposure extends beyond the adjudicatory process.

5. Conclusion

This study examined the considerations that shape Insurance Ombudsman decisions in health-insurance cost-sharing disputes. Across the 15 adjudicated cases, relief is more closely associated with a combined **disclosure-and-application standard**—whether the provision was adequately disclosed and correctly applied—than with the magnitude of the policyholder's financial burden. This pattern is supported by the statistical comparisons and, importantly, by the adjudicators' stated reasons. The evidence does not establish an independent causal effect of disclosure, as disclosure and regulatory application cannot be cleanly separated in the sample.

The contribution is therefore bounded to the adjudicatory setting. The cases suggest that financial harm functions primarily as the consequence of an accepted or rejected contractual provision rather than as an independent basis for adjudicatory relief. The findings should not be interpreted as representative of the wider Indian health-insurance market, given the small and selected nature of the sample. The broader implication is that consumer protection in cost-sharing arrangements depends not simply on permitting or restricting such provisions, but on ensuring that **risk transfer is predictable and correctly administered**. For insurers and regulators, this highlights the importance of decision-relevant disclosure and consistent claims application. Larger case-level and claims datasets would be required to determine whether the pattern observed in the adjudicatory record extends to the wider market.

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Appendix

A.1 Coding instrument and derived quantities

The full anchored protocol applied in Section 3, and applied independently by the blind second coder under the reliability test reported in Section 3, is reproduced in Table A1.

Table A1. Coding instrument with anchored three-level classification

Criterion	Operational definition	Anchored classification rule
Transparency	Does the KID explicitly state the cost-sharing provision in plain language?	0 = absent from KID; 1 = present but technical/undefined; 2 = plain-language with worked example
Predictability	Can the policyholder calculate ex ante out-of-pocket liability before admission?	0 = indeterminate until settlement; 1 = formula requires specialist knowledge; 2 = fixed and pre-calculable
Proportionality	Is the deduction applied within IRDAI rules?	0 = applied to IRDAI-exempt items; 1 = associated items only; 2 = confined to excess room cost
Financial protection	Does residual OOP remain below the CHE threshold?	0 = CHE exceeded at median; 1 = CHE exceeded only at lower quintiles; 2 = below threshold at all quintiles

Transparency and predictability are retained as separate ordinal indicators of disclosure quality. Proportionality is recorded separately because it concerns ex post regulatory application rather than information available to the policyholder at the point of purchase. Financial protection is treated as an outcome characteristic and is not incorporated into the disclosure classification.

A.2 The blind coding protocol

The protocol was executed as follows. Fifteen case files were prepared from the published CIO and IRDAI summaries, each with the Ombudsman's decision, reasoning, and disposition removed, retaining the policy type, the provision at issue, the amounts claimed and settled, and the description of what the policy document did and did not state. A second coder, who had not read this paper and had no knowledge of the awards, classified transparency and predictability for each file using only the anchors in Table A1. In the first round, agreement with the original codes was linear-weighted Cohen's κ of 0.49 for transparency and 0.51 for predictability, with Krippendorff's α of 0.66 across the two blind-coded criteria — below the pre-set thresholds, with disagreement concentrated on the intermediate anchor: all twelve disagreements involved a classification of 1, and nine lay on the 0–1 boundary. The instrument was therefore revised. The intermediate category was redefined to require that the provision be named in the document, the top category reserved for cases also giving a figure or worked example, and a tie-breaking rule added directing coders to the lower category where uncertain between 0 and 1. A second independent coder, with no prior exposure to the cases or to the first round, then

applied the revised instrument. Agreement improved on every measure, to κ of 0.54 for transparency and 0.75 for predictability and α of 0.77. The disclosure classification and the Fisher comparison were recomputed on both sets of blind codes, and both are reported. A re-coding by the present author would not substitute for this, because the codes and outcomes are already known to that coder.

A.3 Extended numerical illustrations

The first illustration applies the 0.60 deduction ratio of Section 4 wrongly to medicines, diagnostics, and consumables — all IRDAI-exempt categories — which is the configuration underlying the reversal in C-05, shown in Table A2.

Table A2. Deduction wrongly applied to exempt items

Item	Hospital charge (INR)	Insurer pays (INR)	Patient OOP (INR)
Room rent (5 days)	25,000	15,000	10,000
Surgeon's fee	80,000	48,000	32,000
Operating theatre	40,000	24,000	16,000
Anaesthesia	20,000	12,000	8,000
Nursing (5 days)	25,000	15,000	10,000
Medicines (wrongly deducted)	30,000	18,000	12,000
Diagnostics (wrongly deducted)	30,000	18,000	12,000
Consumables (wrongly deducted)	50,000	30,000	20,000
Total (incorrect)	3,00,000	1,80,000	1,20,000 (40.0%)

Misapplication raises OOP from INR76,000 to INR1,20,000.

The second illustration is C-12, the sample's maximum-complexity case: a Senior Citizen policy with sum insured INR3,00,000; room entitlement INR2,500/day; actual INR4,000/day; 20% co-payment; implant sub-limit INR75,000; a 7-day stay; and ratio 0.625. The order of operations is sub-limit, then proportional deduction, then co-payment on the net admissible amount, as shown in Table A3.

Table A3. Three simultaneous provisions (stacking)

Item	Hospital charge (INR)	Insurer pays (INR)	Patient OOP (INR)
Room rent (7 days)	28,000	17,500	10,500
Surgeon's fee (62.5%)	60,000	37,500	22,500

Item	Hospital charge (INR)	Insurer pays (INR)	Patient OOP (INR)
Operating theatre (62.5%)	35,000	21,875	13,125
Implant (sub-limit 75,000)	1,40,000	75,000	65,000
Anaesthesia (62.5%)	20,000	12,500	7,500
Nursing (62.5%)	17,000	10,625	6,375
Medicines/Diagnostics (exempt)	50,000	50,000	—
Sub-total before co-payment	3,50,000	2,25,000	1,25,000
Co-payment (20% of 2,25,000)	—	(45,000)	45,000
Total out-of-pocket	3,50,000	1,80,000	1,70,000 (48.6%)

Stacking of three provisions yields INR1,70,000 OOP.

Table A4. The 15-case analytical sample

Case	Policy type	Mechanism	Claim (₹)	Settled (₹)	OOP (₹)	Ombudsman finding and source
C-01	Individual	Room-rent cap + proportional deduction	3,00,000	1,80,000	1,20,000	Policyholder. Deduction applied to ICU (IRDAI-exempt). CIO Insurance Ombudsman award.
C-02	Senior Citizen	Co-payment (20%)	2,50,000	2,00,000	50,000	Insurer. Co-pay clear in schedule & KID. CIO Insurance Ombudsman award.
C-03	Family Floater	Proportional deduction (OT)	4,00,000	2,70,000	1,30,000	Policyholder. 'Associated charges' undefined. CIO Insurance Ombudsman award.
C-04	Individual	Room-rent cap + sub-limit	1,85,000	90,000	95,000	Insurer. Both sub-limits in schedule.

Case	Policy type	Mechanism	Claim (₹)	Settled (₹)	OOP (₹)	Ombudsman finding and source
						CIO Insurance Ombudsman award.
C-05	Senior Citizen	Deduction on medicines	5,20,000	3,10,000	2,10,000	Policyholder. Medicines IRDAI-exempt. CIO Insurance Ombudsman award.
C-06	Family Floater	Co-payment + deductible	1,60,000	1,04,000	56,000	Insurer. Both in schedule & KID. CIO Insurance Ombudsman award.
C-07	Individual	Deduction (uniform pricing)	2,80,000	1,50,000	1,30,000	Policyholder. Flat rate; hospital deduction inapplicable. CIO Insurance Ombudsman award.
C-08	Group (Employer)	Cap; master policy undisclosed	3,50,000	2,00,000	1,50,000	Policyholder. Employee not given master policy. CIO Insurance Ombudsman award.
C-09	Individual	Procedure sub-limit (cardiac)	4,80,000	4,30,000	50,000	Insurer. Sub-limit in benefit schedule. CIO Insurance Ombudsman award.
C-10	Senior Citizen	Deduction (medical necessity)	2,20,000	1,10,000	1,10,000	Policyholder. Isolation room clinically required. CIO Insurance Ombudsman award.
C-11	Family Floater	Cap + partial deduction	3,90,000	2,60,000	1,30,000	Partial. OT/surgeon upheld; nursing reversed. CIO Insurance Ombudsman award.

Case	Policy type	Mechanism	Claim (₹)	Settled (₹)	OOP (₹)	Ombudsman finding and source
C-12	Individual	Three provisions stacked	6,00,000	3,20,000	2,80,000	Policyholder. Combination undisclosed; reasonable expectations. CIO Insurance Ombudsman award.
C-13	Family Floater	ICU step-down deduction	4,20,000	2,10,000	2,10,000	Policyholder. ICU categorically exempt. CIO Insurance Ombudsman award.
C-14	Senior Citizen	Daycare sub-limit	95,000	40,000	55,000	Partial. Sub-limit correct; consumables wrongly deducted. CIO Insurance Ombudsman award.
C-15	Individual	PED waiting period + cap	3,80,000	0	3,80,000	Insurer. Claim within 24-month PED window; disclosure adequate. CIO Insurance Ombudsman award.

A.4. The disclosure classification

Table A5 reports case-level disclosure classification, with proportionality playing no part in its construction.

Table A5. Disclosure classification by case (proportionality excluded)

Case	Transparency	Predictability	Disclosure classification	Reasoning	Outcome
C-03	0	0	Low	'Associated charges' undefined	Policyholder
C-08	0	0	Low	Master policy never furnished	Policyholder
C-12	0	0	Low	Combined effect never disclosed	Policyholder

Case	Transparency	Predictability	Disclosure classification	Reasoning	Outcome
C-13	0	0	Low	ICU categorically exempt	Policyholder
C-01	1	0	Intermediate	Deduction applied to exempt ICU	Policyholder
C-05	1	0	Intermediate	Medicines IRDAI-exempt	Policyholder
C-07	1	0	Intermediate	Deduction inapplicable to flat pricing	Policyholder
C-10	1	0	Intermediate	Medical-necessity room	Policyholder
C-11	1	0	Intermediate	Deduction scope unspecified	Partial
C-14	1	1	Intermediate	Consumables wrongly deducted	Partial
C-04	2	1	Intermediate	Both sub-limits in schedule	Insurer
C-02	2	2	High	Co-pay clear in schedule & KID	Insurer
C-06	2	2	High	Both stated in schedule & KID	Insurer
C-09	2	2	High	Sub-limit in benefit schedule	Insurer
C-15	2	2	High	PED window disclosed with dates	Insurer

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